Employer Notices and Other "Need-to Know" Information

KEITH C. MIER
SUTIN, THAYER & BROWNE,
A PROFESSIONAL CORPORATION
6565 AMERICAS PARKWAY NE, SUITE 1000 ALBUQUERQUE, NM 87110
T: 505-883-3395
F: 505-888-6565
KCM@SUTINFIRM.COM

A. Sending required notices to employees

1. Notice of Exchange: Section 1512 of the ACA creates a new Fair Labor Standards Act (FLSA) section 18B requiring a notice to employees of coverage options available through the Marketplace. Employers covered by the FLSA are required to provide applicable notices. Section 18B generally provides that, in accordance with regulations promulgated by the Secretary of Labor, an applicable employer must provide each employee at the time of hiring (or with respect to current employees, not later than October 1, 2013[1]), a written notice. **There is no daily fine associated with noncompliance**.[2]

- Department of Labor Technical Release No. 2013-02 includes guidance[3]
  - The notice should inform employees:
    - About the Health Insurance Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance
    - That, depending on their income and what coverage may be offered by the employer, they may be able to get lower cost private insurance in the Marketplace. If the employer plan's share of the total allowed costs of benefits provided under the plan is less than

[1] Originally the date was March 1, 2013, but the date was changed because the Department of Labor concluded that the notice requirement under FLSA section 18B will not take effect on March 1, 2013 for several reasons. First, this notice should be coordinated with HHS's educational efforts and Internal Revenue Service (IRS) guidance on minimum value. Second, we are committed to a smooth implementation process including providing employers with sufficient time to comply and selecting an applicability date that ensures that employees receive the information at a meaningful time. The Department of Labor expects that the timing for distribution of notices will be the late summer or fall of 2013, which will coordinate with the open enrollment period for Exchanges.

[2] *See* http://www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html

[3] The Secretary of Labor has delegated responsibility for FLSA section 18B rulemaking to the Employee Benefits Security Administration (EBSA) within the Department of Labor.

60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the employee purchases a qualified health plan through the Marketplace; and

- That if the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

- Employers are required to provide the notice to each new employee at the time of hiring beginning October 1, 2013. For 2014 (and beyond), the Department will consider a notice to be provided at the time of hiring if the notice is provided within 14 days of an employee's start date. With respect to employees who are current employees before October 1, 2013, employers are required to provide the notice not later than October 1, 2013. The notice is required to be provided automatically, free of charge. The notice must be provided in writing in a manner calculated to be understood by the average employee. It may be provided by first-class mail. Alternatively, it may be provided electronically if the requirements of the Department of Labor's electronic disclosure safe harbor at 29 CFR 2520.104b-1(c) are met.
- The U.S. Department of Labor has two model notices to help employers comply. There is one model for employers who do not offer

a health plan and another model for employers who offer a health plan to some or all employees:

- http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf
- http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf

- In general, under COBRA, an individual who was covered by a group health plan on the day before a qualifying event occurred may be able to elect COBRA continuation coverage upon a qualifying event (such as termination of employment or reduction in hours that causes loss of coverage under the plan).[4] Individuals with such a right are called qualified beneficiaries. A group health plan must provide qualified beneficiaries with an election notice, which describes their rights to continuation coverage and how to make an election. The election notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives the notice of a qualifying event.
  - The election notice is required to include:
    - The name of the plan and the name, address, and telephone number of the plan's COBRA administrator;
    - Identification of the qualifying event;
    - Identification of the qualified beneficiaries (by name or by status);
    - An explanation of the qualified beneficiaries' right to elect continuation coverage;
    - The date coverage will terminate (or has terminated) if continuation coverage is not elected;

[4] *See* 26 CFR 54.9815-2719T(e), 29 CFR 2590.715-2719(e), and 45 CFR 147.136(e), originally published on July 23, 2010, at 75 FR 43330 and amended on June 24, 2011, at 76 FR 37208.

- How to elect continuation coverage;
- What will happen if continuation coverage isn't elected or is waived;
- What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events;
- How continuation coverage might terminate early;
- Premium payment requirements, including due dates and grace periods;
- A statement of the importance of keeping the plan administrator informed of the addresses of qualified beneficiaries; and
- A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the plan administrator and in the plan's summary plan description (SPD).

- Some qualified beneficiaries may want to consider and compare health coverage alternatives to COBRA continuation coverage that are available through the Marketplace. Qualified beneficiaries may also be eligible for a premium tax credit (a tax credit to help pay for some or all of the cost of coverage in plans offered through the Marketplace).
- The Department of Labor has a model election notice that plans may use to satisfy the requirement to provide the election notice under COBRA. The model election notice is available in modifiable, electronic form on the Department's website at www.dol.gov/ebsa/cobra.html. A clean copy is available, as is a

redline from the prior model notice to help interested stakeholders identify the changes.

2. Employee's Summary of Benefits and Coverage (SBC): The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (the Departments) published the final SBC rules on February 14, 2012.[5] For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012.

- Plans and issuers may combine information for different cost-sharing selections (such as levels of deductibles, copayments, and co-insurance) in one SBC, provided the appearance is understandable.[6] This information can be presented in the form of options, such as deductible options and out-of-pocket maximum options. In these circumstances, the coverage examples should note the assumptions used in creating them. An example of how to note assumptions used in

[5] *See* 26 CFR 54.9815-2715, 29 CFR 2590.715-2715, and 45 CFR 147.200, published February 14, 2012 at 77 FR 8668.

[6] *See* 77 FR 8668, 8670-71 (February 14, 2012) and page 1 of Instruction Guide for Group Coverage available at http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf; last visited February 23, 2015. *See also* Written translations in Spanish, Chinese, Tagalog and Navajo will be available at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.

creating coverage examples is provided in the Departments' sample completed SBC.[7]

- The final regulations require that the SBC be provided in several instances:
  - *Upon application*. If a plan (including a self-insured group health plan) or an issuer distributes written application materials for enrollment, the SBC must be provided as part of those materials. For this purpose, written application materials include any forms or requests for information, in paper form or through a website or email, which must be completed for enrollment. If the plan or issuer does not distribute written application materials for enrollment (in either paper or electronic form), the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage.
  - *By first day of coverage (if there are any changes)*. If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC no later than the first day of coverage.
  - *Special enrollees*. The SBC must be provided to special enrollees no later than the date on which a summary plan description is required to be provided (90 days from enrollment).

[7] *See* The Department of Labor's sample completed SBC is available at: www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/sample-completed-sbcfinal.pdf; last visited February 23, 2015.

- *Upon renewal*. If a plan or issuer requires participants and beneficiaries to actively elect to maintain coverage during an open season, or provides them with the opportunity to change coverage options in an open season, the plan or issuer must provide the SBC at the same time it distributes open season materials. If there is no requirement to renew (sometimes referred to as an "evergreen" election), and no opportunity to change coverage options, renewal is considered to be automatic and the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.
- *Upon request*. The SBC must be provided upon request for an SBC or summary information about the health coverage as soon as practical but in no event later than seven business days following receipt of the request. **The Regulations state the seven day requirement requires the summary be postmarked within seven days of the request.**

- The Departments recognize that different combinations of plans, issuers, and their service providers may have different information necessary to provide an SBC. Thus, the Departments have determined that, until further guidance is issued, where a group health plan or group health insurance issuer has entered into a binding contractual arrangement under which another party has assumed responsibility (1) to complete the SBC, (2) to provide required information to complete a

portion of the SBC, or (3) to deliver an SBC with respect to certain individuals in accordance with the final regulations, the plan or issuer generally will not be subject to any enforcement action by the Departments for failing to provide a timely or complete SBC, provided the following conditions are satisfied:

- The plan or issuer monitors performance under the contract,
- If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer has the information to correct it, it is corrected as soon as practical, and
- If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer does not have the information to correct it, the plan or issuer communicates with participants and beneficiaries regarding the lapse and begins taking significant steps as soon as practical to avoid future violations.

- *Electronic Notice of SBC*. With respect to group health plan coverage, an SBC may be provided electronically: (1) by an issuer to a plan, and (2) by a plan or issuer to participants and beneficiaries *who are eligible but not enrolled for coverage*, if:
  - The format is readily accessible (such as in an html, MS Word, or pdf format);
  - The SBC is provided in paper form free of charge upon request; and

- If the SBC is provided via an Internet posting (including on the HHS web portal), the issuer timely advises the plan (or the plan or issuer timely advises the participants and beneficiaries) that the SBC is available on the Internet and provides the Internet address. Plans and issuers may make this disclosure (sometimes referred to as the "e-card" or "postcard" requirement) by email.

- An SBC may also be provided electronically by a plan or issuer to a participant or beneficiary *who is covered under a plan* in accordance with the DOL's disclosure regulations at 29 CFR 2520.104b-1. Those regulations include a safe harbor for disclosure through electronic media to participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Under the safe harbor, other individuals may also opt into electronic delivery.
- With respect to individual market coverage, a health insurance issuer must provide the SBC, in either paper or electronic form, in a manner that can reasonably be expected to provide actual notice. The SBC may not be provided in electronic form unless:
  - The format is readily accessible;
  - If the SBC is provided via an Internet posting, it is placed in a location that is prominent and readily accessible;

- The SBC is provided in an electronic form which can be retained and printed; and
- The issuer notifies the individual that the SBC is available free of charge in paper form upon request.

- In addition, a health insurance issuer offering individual market coverage, that provides HealthCare.gov with all the content required to be provided in the SBC, will be deemed compliant with the requirement to provide an SBC upon request prior to application. However, issuers must provide the SBC in paper form upon request for a paper copy, and at all other times as specified in the regulations. In addition, as stated in the regulations, unless the plan or issuer has knowledge of a separate address for a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form).
- For disclosures from issuers to group health plans, and with respect to individual market coverage, the SBC must be provided beginning September 23, 2012.

3. Tips for communicating any changes to employees:

- Inform employees anytime a change to coverage is made (the requirement is to notify employees at least 60 days prior to the date that a "material change" to the health plan will become effective). A material changes occurs when:

- Changes to the health plan occur at a time other than renewal of coverage
- A change to the health benefits affects the contents of the SBC
- Information is not reflected in the most recent SBC

- Communicate with employees in writing. Section 18B of the FLSA requires a written notice, thus get in the practice of providing written notices to employees.
- Communicate using non-lawyer English
- Send a cover letter. Sending a cover letter gives the employer a chance to explain the required notice in the plan's own terms and to convey other messages about health coverage or health promotion. For example, cover letters might communicate a smoking-cessation program, encourage participation in wellness programs, remind employees to get a flu shot or an annual physical or educate them about the importance of seeking care from network providers. Plan sponsors may also want to take the opportunity to remind employees about other benefits the plan provides, such as full coverage of preventive services with no copayments or reduced costs when the mail-order service is used
- Utilize a website. Some applicable rules require notices be mailed to employees in writing, however, there is no restriction on the plan sponsor posting the changes on its website and including some explanation of changes.

- Utilize a video. Record a video with an individual explanation of changes and provide a link to the video to your employees. This will help folks really understand changes – ensure the spokesperson encourages questions following the video and include contacts within your company or with the plan sponsor.
- Utilize email if possible but require a mechanism ensuring employees receive notice (also make sure any electronically communicated information meets the requirements of the Department of Labor's electronic disclosure safe harbor at 29 CFR 2520.104b-1(c)).
- Utilize required notices as opportunities to communicate other changes. Since you have to provide individual notices, in writing, include other company announcements to save on costs.
- Plan ahead and ensure all notices are prepared prior to open enrollment so that ACA notices can be combined into one mailing.
- Include required notices in new employee welcome packages.
- Create an intranet so that employees have a place to turn for information related to the health plan.
- *Consider* social media, and how some information can be shared with employees.

B. Your employee handbook: review your policies

- Definition of a Full-Time Employee. As already discussed, under the ACA, an employee who works 30 hours or more a week is considered full time. Employers should consider revising their benefit eligibility and other policies to reflect the ACA's requirements.

- Part time should be clearly defined if the term's use with regard to health-care plans differs from the term's use with regard to hours, wages and vacation.
- For calculating full-time status, the ACA provides for:
    - **Look-back measurement period** – No longer than 12 months and no shorter than three consecutive months to determine if an employee has full-time status and is eligible for health care coverage.
    - **Administrative period** – Up to 90 days for employer to calculate and notify employees of full-time status, enroll/disenroll employees and carry out similar administrative tasks.
    - **Stability period** – Once employees are notified of their full-time status, they will be considered full-time for a stability period that can be no less than six and no more than 12 months (and not longer than the measurement period, except in this first year), regardless of hours worked during this time. At the end of the stability period, the employer may again measure the employee's status.
        - The rules differ for new employees and ongoing employees, and between the initial measurement period and ongoing employee measurement period, as described in Treasury Notice 2012-58.[8]
- Employers should specify in the handbooks what type of method is being used for calculating part-time employees and employer waiting periods for health-care coverage, including:

[8] *See* Treasury Notice 2012-58; available at http://www.irs.gov/pub/irs-drop/n-12-58.pdf

- A disclaimer that the handbook only summarizes the benefits the company offers and detailed information can be found in Summary Plan Descriptions (SPDs) or other relevant plan docs.
- Information on the location and/or source of where SPDs can be obtained.
- A statement informing employees that eligibility for participation in any benefit plan is governed by the terms of the plan document in question.
- A statement letting employees know that benefits described in the handbook may be modified or discontinued at the company's discretion.

- Short term and high turnover employees. Employers have not historically offered coverage to short term and high turnover employees and many thought the final regulations would provide an exception for these employees. The final regulations do not contain any special rules for these employees. Some employer's concerns are alleviated through the 3 month rule for new full time employees and the ability to use an initial measurement period for new variable hour or seasonal employees.
- Student interns. Again, the final regulations do not provide a general exception for student employees except those in a federal work study program. This means employers that hire full time paid student interns and do not want to offer these interns coverage will generally need to limit the interns' employment to three full calendar months or less.

- Full time unpaid interns' hours are not counted as hours of service, and the employer does not need to offer them coverage.

- Employers should consider revising policies and procedures to prohibit retaliating against an employee for any activity protected under Title I of ACA (more on this in Section D below). Employers should also ensure that management and supervisory personnel are well trained in these ACA provisions and in procedures for appealing complaints to OSHA.

C. Tips for managing your workforce below the penalty thresholds

- Time keeping, time keeping, time keeping!
- Create a policy for supervisors, and management related to timekeeping and scheduling.
  - Ensure employees working less than 30 hours consistently work 30 or fewer hours.
  - Scheduling is IMPORTANT. Ensure supervisors are aware.
  - Conduct supervisory training!
- Develop a two supervisor policy for scheduling work.
  - One supervisor interacts with the employees regarding scheduling, and the schedule is then reviewed by a manager or another supervisor.
- Work outside the scheduled hours must be approved as far in advance as possible.
  - Don't allow a front line supervisor to make day-to-day decisions without considering the likelihood an employee will work more than 30 hours. Maintain the two person approval requirement.

- Look for scheduling software that can enable electronic tracking of employee time, which also allows for electronic updates to supervisors or managers when an employee is reaching her limit, or has been scheduled for more than 30 hours.
- Be careful with manipulating the workforce. Under the Employee Retirement Income Security Act (ERISA) Section 510 an employer can face liability for modifying their employees' hours of work to prevent their qualification as a full-time employee. ERISA Section 510 states:
    - It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . por for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan.

D. Avoiding discrimination accusations and retaliation claims for health plan changes

- ACA Retaliation Protections. The ACA offers employees protection from retaliation. Section 1558 of the ACA amends the Fair Labor Standards Act (section 18C), making it illegal to "discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment" where the employee has provided "information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of (Title I of the ACA)" to their employer, the Federal Government, or the attorney

general. Moreover, Section 1558 states " no employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions , or other privileges of employment because the employee….has…received…a subsidy [for buying individual insurance]."

- The Department of Labor ("DOL") has specified that the following are adverse employment actions sufficient to trigger the whistleblower protections of the ACA[9]:
  - Firing or laying off;
  - Blacklisting;
  - Demoting;
  - Denying overtime or promotion;
  - Disciplining;
  - Denying benefits;
  - Failure to hire or rehire;
  - Intimidation;
  - Making threats;
  - Reassignment affecting prospects for promotion; and
  - Reducing pay or hours.
- In addition to health insurance reforms, Section 1558 also protects employees from retaliation for:
  - Reporting violations of the various reforms found in (Title I of the ACA)
  - Receiving a premium tax credit or a cost sharing reduction for enrolling in a qualified health plan.
- The DOL has stated the whistleblower protections under the ACA are "analogous" to those under the Sarbanes-Oxley Act of 2002.

[9] *See* 29 CFR Part 1984.

- Employees can file a whistleblower claim with Occupation Safety and Health Administration (OSHA) within 180 days after the retaliation. Employees can visit, call, or send a written complaint to the nearest OSHA office.[10]
- Remedies include reinstatement, affirmative action to abate violation, back pay with interest, front pay, compensatory damages, and an award of up to $1000 for attorney fees.

- Avoiding Discrimination and Retaliation Claims. Don't let it happen to your company!
- Employers shouldn't pressure employees not to purchase subsidized individual insurance on the Exchange.
- Don't make statements to employees such as "jobs will have to be cut if too many people buy insurance on the Exchanges."
- Try to avoid making employment decisions based on the costs of insurance; doing so may land an employer squarely contrary to the Section 1558.
- Inform all employees of changes to any benefits.
- Inform employees of changes to plan requirements, ensure all required notices are provided to **all** employees.
- When purchasing insurance ensure the policy does not make it difficult for individuals with chronic illness to maintain affordable coverage as much as possible.

[10] *See* OSHA Fact Sheet: Filing Whistleblower Complaints under the Affordable Care Act; *available at*: https://www.osha.gov/Publications/whistleblower/OSHAFS-3641.pdf; last visited March 2, 2015.

- If you conduct a "health screening" related to your insurance on an annual basis, be careful with questions that could lead to a perception of discrimination. Insurance cannot cost more simply based on gender or health status.
- Consider creating an anti-discrimination anti-retaliation policy (previously discussed).
- For the purposes of discrimination, New Mexico recognizes the following protected classes: Race, Sex (Gender), National Origin, Ancestry, Religion, Age, Veteran Status, Serious Medical Condition or physical or mental disability, Sexual Orientation, Gender Identification, and Spousal Affiliation.
- If an accusation occurs:
    - Conduct an investigation into any related claims of discrimination or retaliation.
    - Start with an internal investigation if your company has a functioning HR department. If not, look to an outside consultant or attorney (you may not want to utilize your corporate in house counsel if possible)
    - If the internal investigation leads to findings leaning toward discriminatory behavior contact your attorney (you may need to also contact your insurance)!
    - Communicate with the complaining employee. Explain that you are taking the complaint seriously.

- Tell the employee (during the investigation) that you want to hear about anything the employee considers hostile or negative.
- Refer the employee to your anti-discrimination anti-retaliation policy.
- Explain you won't tolerate discrimination or retaliation from anyone in the company.
- Keep confidential any complaints that you receive.
    - The fewer people who know about a complaint, the smaller the chances are that someone will discriminate or retaliate against the complaining employee. (Of course, when you investigate the employee's complaint, you will have to tell some people about the issue).
    - Make sure only the people who absolutely need to know are made aware of the complaint.
    - Interview **all** employees who may have information.
    - The Company HR Department or the consultant/attorney investigating should create a report following the investigation with findings, conclusions, and recommendations.
- Once the report is presented, take action!
    - Management must make business decisions based on the report and develop a letter to those affected by the decision; especially the complaining employee!

        - Consider all of the recommendations in the report. Decide which are in the Company's best interest and effectuate those.
        - Other recommendations should also be addressed even if the Company intends not to follow the recommendation.
    - If a lawsuit ensues, the report will likely become evidence, and it should be treated as such.
- Document, document, document.

E. How are unions treated differently under ACA

- The final regulations clarify that an offer of coverage made to an employee on behalf of a contributing employer under a multiemployer or single-employer Taft-Hartley plan is treated as made by the employer.
- A Taft-Hartley plan is a health benefit plan collectively bargained between unions and multiple employers.
- The final regulations also offer transition relief under the Shared Responsibility rules to employers participating in multiemployer plans.
- Under the transition relief, employers that make contributions to a multiemployer plan pursuant to a collective bargaining agreement under which coverage is offered to full-time employees who satisfy the plan's eligibility conditions and their dependents are not liable for a penalty if the coverage satisfies the affordability and minimum value requirements. (See previous discussion regarding definitions of "minimum value" and "affordability".)
- Union employees who are ensured subject to a Taft-Hartley plan will not be able to take advantage of tax incentives available to others.

- Many of the Taft-Hartley plans will be subject to the "Cadillac tax," which is an excise tax that will now go into effect Jan. 1, 2018. A 40% tax will be levied on every dollar of total premiums paid above $10,200 for individual health plans and $27,500 for family plans.

F. Other business obligations

- *Employer-mandate delayed again:* The administration delayed for an additional year provisions of the employer mandate, postponing enforcement of the requirement for medium-size employers until 2016 and relaxing some requirements for larger employers. Businesses with 100 or more employees must offer coverage to 70% of their full-time employees in 2015 and 95% in 2016 and beyond. [11]
- Revise Health Insurance Portability and Accountability Act privacy and security policies and procedures for compliance with final regulations.
- Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 - Amends the Internal Revenue Code to:
    - (1) repeal requirements for the reporting to the Internal Revenue Service (IRS) of payments of $600 or more to corporations that are not tax-exempt and of gross proceeds paid in consideration for any type of property;
    - (2) repeal requirements for reporting payments made with respect to rental property which is not part of a trade or business; and

[11] *See* Final Regulations Shared Responsibility for Employers Regarding Health Coverage available at http://online.wsj.com/public/resources/documents/ACA-FullRule-02102014.pdf

- (3) increase the limitation on recapture of excess advance payments of the tax credit for health insurance premiums.

- While large employers may think that subdividing into smaller companies may provide some relief from the Employer Mandate, PPACA and its regulations apply the IRS “controlled group” rules found in IRS Code § 414 (b) and 414(c). The controlled group rules essentially state that “all employees of all corporations which are members of a controlled group of corporations" and "all employees of trade[s] or business[es] (whether or not incorporated) which are under common control" are to be treated as employed by a single employer.
  - Generally, there are three types of “controlled groups”:
    - Parent-subsidiary groups (one business owns 80 percent or more of another business or businesses);
    - Brother-sister groups (five or fewer common owners; the common owners must own at least 80 percent of each business; and the combined identical ownership must be 50 percent or more); and
    - Combined ownership groups (each organization is a member of either a parent-subsidiary or brother-sister group and at least one corporation is: the common parent of a parent-subsidiary and a member of a brother-sister group).

- Accordingly, any of the organizations that are "controlled groups" are treated as a single employer under PPACA. Thus, an employer cannot simply divide its organization into separate organizations to avoid the Employer Mandate under PPACA.
- The ACA calls for employers and insurers to report information including:
    - For Internal Revenue Code Section 6055:
        - Information about the entity providing coverage, including contact information.
        - Which individuals are enrolled in coverage, with identifying information and the months for which they were covered.
    - For Internal Revenue Code Section 6056:
        - Information about the employer offering coverage (including contact information and the number of full-time employees).
        - For each full-time employee, information about the coverage (if any) offered to the employee, by month, including the lowest employee cost of self-only coverage offered.
- A reporting entity will not be subject to penalties for failure to comply with the section 6055 and 6066 information reporting provisions if it first reports beginning in 2016 for 2015 (including the furnishing of employee statements).
- W-2 Reporting: W-2 reporting of employer-provided healthcare coverage is now required for all employers filing 250 or more W-2s for the prior calendar year. These employers are required to report the value of employer-

sponsored healthcare coverage regardless of whether it is paid by an employer on behalf of the employee (as excludable income), by an employee through a cafeteria plan, or by an employee on an after-tax basis.[12]

- Preventive Care: All non-grandfathered health plans must now cover a variety of preventive care services for women with no participant cost-sharing. These services include contraceptive methods and counseling, well-woman visits, and screening and counseling for interpersonal domestic violence, among others.[13]
- Health FSAs: The limit for employee contributions to medical flexible spending accounts is now $2,500. Contribution limits for 2014 and beyond will be indexed to cost-of-living adjustments using increments of $50.[14]
- Medicare and FICA: For individuals earning more than $200,000 and joint filers earning more than $250,000, the Medicare Part A (hospital insurance) tax has increased to 2.35 percent. To apply the new tax increase, employers should use $200,000 as a baseline income for each employee because they will not know the total household income for those filing jointly.[15]
- Medicare Part D Subsidy: The tax deduction for employers who receive Medicare Part D retiree drug subsidies has been eliminated. The tax

[12] *See* www.irs.gov/uac/Form-W-2-Reporting-of-Employer-Sponsored-Health-Coverage for further information.
[13] *See* www.hhs.gov/news/press/2013pres/02/20130201a.html for further information.
[14] *See* www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions for further information.
[15] *See* www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax for more information.

deduction has also been eliminated for individuals earning $85,000 or more and married couples earning $170,000 or more.[16]

- Patient-Centered Outcomes Research Institute (PCORI) Fee: Insurance carriers and sponsors of self-insured plans, retiree-only plans, and grandfathered plans are required to fund PCORI through the payment of certain per capita fees. Employers will only be directly liable for the fee if they sponsor a self-insured plan, although insurers will seek to pass through the cost of the fee for insured coverage through to employers in the form of higher premiums.[17]
- Medical Loss Ratio (MLR) Rebates: The Patient Protection and Affordable Care Act requires issuers of fully insured plans to provide rebates if they do not spend at least 85 percent of the prior year's health insurance premiums on healthcare services. It is important to note that MLR rebates have differing requirements and tax consequences dependent upon the situation.
- Stricter limits on Annual Dollar Limits on Essential Health Benefits: For plan years beginning on or after September 23, 2013, plans will be subject to a complete bar on the use of not only lifetime limits, but also any annual limits on "essential health benefits." Employers and plans can continue to impose annual and lifetime dollar limits on non-essential health benefits.
- Cost-Sharing Limitations for Non-Grandfathered Plans: For plan years beginning on or after January 1, 2014, non-grandfathered individual and small group insurance policies cannot impose maximum deductible limits

[16] *See* www.irs.gov/uac/Newsroom/Frequently-Asked-Questions:-Retiree-Drug-Subsidy for more information.
[17] *See* www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf for more information.

that exceed $2,000 for self-only and $4,000 for family coverage. Large group insurance and self-funded plans are not subject to these maximum deductible limits. Essentially all policies cannot impose a maximum out-of-pocket limit on cost-sharing that exceeds $6,250 for self-only coverage and $12,500 for family coverage (as adjusted for cost of living).